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Nevada Title XXI State Plan

STATE CHILD HEALTH PLAN
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

New section 2101(b) required under 4901 of the Balanced Budget Act of 1997

State/Territory: Nevada

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR 457.40(b))

_____ _____

Michael J. Willden **Date**
Director, Department of Health and Human Services

(Signature of Governor or designee of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c)

Name: Charles Duarte	Position/Title: Administrator, Division of Health Care Financing & Policy DHCFP
Name: Elizabeth Aiello	Position/Title: Deputy Administrator, DHCFP
Name: Lynn Carrigan	Position/Title: Administrative Services Officer IV, DHCFP

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2 ☐ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☐ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on

which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4 Original Plan
Effective July 1, 2011 changed the CHIP designation to combination for purposes of claiming Federal Financial Participation (FFP) for CHAP eligible's effective date of service July 1, 2009, as a result of the elimination of the resource test.

Implementation Date: September 1, 2011

SPA # 10-001, Purpose of SPA: Change State Designation
Proposed effective date: July 1, 2011

Proposed implementation date: September 1, 2011

1.4- TC **Tribal Consultation (Section 2107(e)(1)(C))** Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

TN No: Approval Date Effective Date _____

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1 Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). **To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (see Section 10 for annual report requirements).** (42 CFR 457.80(a))

Uninsured Children

Based on the State Demographer's 2002 population estimates, DHCFP has estimated that there are 69,000 children in Nevada who are uninsured living in families with incomes under 200% of federal poverty level. Of these, as many as 50% may be eligible for Medicaid. These numbers are based on limited and sometimes seemingly contradictory data.

For example, the U.S. Census Bureau estimates that for 1996, there were 45,000 uninsured children under 200% of federal poverty level in Nevada, but also estimated that there were 77,000 uninsured at all income levels. This would mean that less than 60% of all uninsured would be under 200% of federal poverty level. The national average is 73%. Only five other states (Alaska, Massachusetts, Vermont, Hawaii, and New Jersey) are under 60%, all of whom have significantly higher Medicaid eligibility levels than Nevada, resulting in a greater level of coverage for low-income children.

With regard to demographic data, the best information comes from a survey of the uninsured in Nevada completed in June 2000, and updated as of January 2003, by the Great Basin Primary Care Association and the State Demographer's 2002 population estimates. The following chart reports on these findings as follows:

Number of Uninsured Children in Nevada by Region

Age in Years	Washoe County	Clark County	Rural Counties	Totals
Less than 6	**6,209**	**30,493**	**3,534**	**40,236**
6 to 18	**11,363**	**51,644**	**9,015**	**72,022**
TOTAL	**17,572**	**82,137**	**12,549**	**112,258**

Estimates of Nevada Populations

According to the current Nevada State Demographer's data, Nevada's total population is 2,210,650. Nevada's children age 0-19 comprise the following races by age and sex:

Age in Years	White	Black	American Indian	Asian	Hispanic	Total
<5	**103,601**	**11,157**	**1,594**	**9,563**	**33,471**	**159,386**
5 to 19	**298,148**	**32,108**	**4,587**	**27,521**	**96,325**	**458,689**
Total	**401,749**	**43,265**	**6,181**	**37,084**	**129,796**	**618,075**

Language spoken at home by Nevadans

According to the 2000 Census Supplementary Survey Summary Tables, Nevada's language spoken at home is as follows:

Nevadans Age >5 years	No English at home
78% Speak English at home	81% Speak Spanish at home
5% No English at home (see breakdown at right)	19% Speak language other than English or Spanish
17% Don't speak English well	

Public Health Insurance Coverage

Medicaid is Nevada's major public health insurance program. In 1967, Nevada implemented the Medicaid program for the Aid to Families with Dependent Children (AFDC) now Temporary Assistance for Needy Families (TANF), Child Welfare, Aged, Blind, and Disabled populations, and in 1985 implemented the Child Health Assurance Program (CHAP) for pregnant women and later for pregnant women with children. Nevada is at the federal minimums for eligibility, 133% of the federal poverty level (FPL) for children up to age six and 100% of FPL for children six and older born on or after October 1, 1983. Currently, TANF and CHAP Medicaid eligible children residing in Clark County are enrolled in mandatory managed care, with the exception of disabled children and those children who reside more than 25 miles from a primary care physician (PCP) and participating hospital, pursuant to NAC 695C.160.

Nevada Check Up

Nevada Check Up provides access to affordable health insurance to children in working, low-income families. The program features simplified mail-in eligibility applications and low premiums while providing a comprehensive health benefits package.

Differences between Nevada Check Up and Nevada Medicaid – There are areas where Medicaid policy and Nevada Check Up policy differ. They are:

1) Residential Treatment Centers (RTC) – In Nevada Check Up, it remains the HMO's responsibility to provide reimbursement for all medical care (physician, optometry, laboratory, dental and x-ray services, etc.) for participants who are receiving services in an RTC. The RTC bed day rate is covered by FFS.

   In Medicaid, those who are admitted to an RTC are disenrolled from the HMO and receive all Medicaid-covered services as FFS recipients.

2) Severely Emotionally Disturbed (SED)/Seriously Mentally Ill (SMI) – In Nevada Check Up, this group must receive evaluation and medically appropriate services through a FFS provider if the family resides in a FFS area. In mandatory HMO geographic areas, SED determinations don't permit disenrollment from the HMO, so the HMOs will provide appropriate services. In Medicaid, once a diagnosis of SED or SMI is confirmed through evaluation, a recipient may elect to disenroll from the HMO and the HMO must notify DHCFP of such election.

3) Newborns – In Nevada Check Up, if a family is expecting a child, whether the adult female in the home or one of the enrolled children, Nevada Check Up must be notified within 14 days of the birth, the newborn, if eligible, will be added to the family as of its date of birth. If the notification criterion is not met, the child, if eligible, will be added the next administrative month following notification. A newborn cannot be enrolled before a family's start date. A newborn will begin services at the same time as the other children in the family. One exception for the Checkup program is if the mother has *other* coverage for the newborn, and she has other children enrolled in Nevada Check Up, the newborn will be enrolled in Nevada Check Up as of the first day of the next administrative month following date of birth.

In Medicaid, all children born to Medicaid-enrolled mothers are enrolled as of their date of birth.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42 CFR 457.80(b))

2.2.1 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Nevada currently has several initiatives to enroll children in Medicaid and Nevada Check Up. These include outreach and referral services to the Women, Infant, and Children (WIC) centers, Federally Qualified Health Centers (FQHCs), Special Children's Clinic (SCC), Baby Your Baby program (BYB), Family Resource Centers (FRCs), and the Family to Family program. In addition, out stationed eligibility workers are in certain public hospitals and federally qualified health centers in order to provide these outreach and referral services. The descriptions of these programs are as follows:

1. The Medicaid program is administered by the Division of Health Care Financing and Policy and provides health coverage to low-income and disabled Nevada children. Nevada takes the following steps to enroll children in Medicaid:

    a. Nevada State Welfare District Offices located throughout the state determine a person's eligibility for TANF, CHAP, and Medicaid. If applicants appear to be Nevada Check Up eligible, rather than Medicaid, they are appropriately referred.

    Out stationed sites (FQHCs, county hospitals, and local county health departments) help people apply for Medicaid or Nevada Check Up and send their applications and eligibility determination to the local Nevada State Welfare District Office or to the Nevada Check Up office. Local public health agencies identify low income, uninsured children through referrals from a variety of sources including: WIC, child health and

immunization clinics, community health and social services agencies, and schools.

2. Women, Infants and Children (WIC) provides nutritious food to supplement the regular diet of pregnant women, infants, and children under age five who meet state income standards. Women and children under five years old qualify if the combined family income is at or below 185% of the federal poverty level. WIC staff encourages pregnant women and parents in this program to apply for Medicaid or Nevada Check Up, depending on their income level.

3. Federally Qualified Health Centers offer health care to low-income people. Nevada has three (3) federally qualified community health centers. The centers provide primary care services including care for acute and chronic illness, injuries, emergency care, diagnostic services and prescriptions.

   Community health centers take the following steps to enroll children in Medicaid or Nevada Check Up:

   1. Provide a financial screen for each new patient or family
   2. Provide information on and explanation of the program(s) for which family members may be eligible.
   3. Assist with completing applications and collecting required documentation.
   4. Forward applications to the determining agency and communicate with family about eligibility status.

   If a patient/family is not eligible for any program, the community health center will provide the health care services and will use its sliding fee scale according to family size and income to determine the fee.

4. Special Children's Clinic
   The Nevada Health Division, Special Children's Clinic (SCC) provides direct services to low-income children ages 0-3 under the Maternal and Child Health Block Grant (Title V). Services include well child clinic services, including developmental and physical assessments and immunizations. Children who appear to qualify for Medicaid or Nevada Check Up are encouraged to apply.

5. Baby Your Baby Program
   Baby Your Baby staff can provide Nevada Check Up applications and information to expectant mothers for future use in insuring their newborns. The state Title V program supports Baby Your Baby (BYB), which is a statewide multi-media bilingual campaign to promote early entry of pregnant women into prenatal care. In 2002 BYB assisted 9,768 women seeking services through the information referral line, and has assisted 111,035 women since the program's inception. When appropriate, these women were referred to Medicaid and Title V prenatal care programs.

6. Family Resource Centers
   A total of 36 Family Resource Centers (FRCs) have been established in high risk neighborhoods throughout Nevada, and an additional 2 are scheduled to open in the next year. The FRCs are community based centers run by not-for-profit organizations with state grants and private contributions. Their aim is to provide information about available social services including Medicaid and Nevada Check Up, and how to access those services. Sites also provide some services (e.g. child care) based on the needs of the community. Nevada Check Up staff have participated with Family Resource Centers in the coordination of health fairs.

7. Community Connections/Family to Family Program
   The Family to Family program is an initiative aimed at informing new mothers of the services that are available to them and how to access such services. A total of 19 centers have been established throughout the state. These centers are community based and operate as public/private partnerships. New mothers are able to receive a home visit, get questions answered about parenting issues and services available to aid them in raising their children, including health insurance through Medicaid and Nevada Check Up.

8. Tribal Administrators, Tribal Clinics, and Indian Health Services (IHS)
   Nevada Check Up staff attends and participates in meetings of the Native American Advisory Council, as mandated by Nevada law, in order to share information and receive advice as to the needs of the Native American tribes in Nevada. Application training and program updates are also provided by program staff.

9. Covering Kids and Families Grant (Robert Wood Johnson Foundation – RWJ)
   There are northern, southern and statewide coalitions whose members direct the activities of Covering Kids and Families staff and volunteers. Covering Kids and Families coordinators work with community-based organizations, schools, private businesses, and the state to promote the enrollment of children in appropriate health insurance programs. They provide applications for Medicaid and Nevada Check Up to those who appear to be eligible for public programs when no private insurance is available to them. Their employees also assist applicants in the proper completion and submission of applications.

2.2.2 The steps this state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public/private partnership.

Other than the referrals received from Family Resource Centers, there are no public/private partnerships in Nevada offering health insurance to low-income children.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as Title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42 CFR 457.80(c))

This issue is addressed in the above Section 2.2.

Section 3. Methods of Delivery and Utilization Controls

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1 Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42 CFR 457.490(a))

The State assures that the delivery of child health assistance using Title XXI funds will be through a choice of State contracted managed care organizations (MCO) primary care providers, or through individually enrolled Medicaid providers where HMOs are not available. In rural areas, services are delivered through Medicaid fee-for-service providers. The State assures that contracts with managed care organizations will comply with all pertinent sections of 1932 and 1903 (m) of the Social Security Act. Contract quality standards will be based on the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards and Quality Improvement System for Managed Care (QISMC) Standards.

The contracted MCOs must develop their own provider networks. The physicians, hospitals and ancillary service providers deliver a comprehensive benefit package described in Section 6.2. The DHCFP requires MCOs to have a sufficient provider network to serve its enrollees. Managed care organizations must offer a contract to Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), public hospitals, and the University Of Nevada School Of Medicine, at terms that are at least equal to their standard provider contracts. If a child loses Medicaid coverage and becomes eligible for Nevada Check Up, the child will be able to remain with the same HMO.

Reimbursement of HMOs is at a rate determined using actuarial principles. Other Nevada Check Up providers are reimbursed using the Medicaid fee-for-service rates.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42 CFR 457.490(b))

The MCOs which contract with the Nevada Check Up program are primarily responsible for utilization control and review functions. Nevada Check Up contract standards require a participating HMO to have adequate utilization control and review management staff and procedures to assure that covered services provided to enrollees are medically necessary and appropriate. Before being approved for participation in

the program, MCOs must develop and have in place utilization review policies and procedures that include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting established criteria. MCOs also must develop procedures for identifying and correcting patterns of over and under utilization on the part of their enrollees.

The MCOs may require a prior authorization for a given service. The child's primary care physician (PCP) is responsible for obtaining all necessary prior authorizations. MCOs are not permitted to require prior authorization for emergency care or preventive services.

MCO compliance with utilization management contracts standards will be monitored by DHCFP staff and/or an external quality review organization (EQRO). To the extent feasible, compliance monitoring will be combined for Medicaid and Nevada Check Up.

Managed care plans are contractually required to track the utilization of benefit services and to submit such data to DHCFP on a monthly and/or quarterly basis. Examples of the data include:

- hospital admissions: diagnosis, length of stay
- ambulatory services - visits to primary care physicians and specialists
- drugs

The data collected is analyzed by DHCFP and/or the EQRO to identify utilization issues. Said entities work with the health plans as necessary to resolve identified problems. More information can be found on utilization control in Section 7 - Quality and Appropriateness of Care.

Check Up participants not residing in managed care service areas receive service coverage from individual Medicaid providers who must adhere to Medicaid fee-for-service policies and procedures. Utilization review policies and procedures will follow Medicaid Title XIX practices, including protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims criteria. Utilization review is done cooperatively with Nevada Medicaid's Surveillance, Utilization and Review Subsystem (SURS) Unit.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42 CFR 457.305 (a) and 457.320 (a))

4.1.0☒ Citizenship: In accordance with Section 211 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Nevada adopted policy adding a new eligibility requirement that children applying for Nevada Check Up who declare to be a United States citizen meet citizenship verification requirements. Nevada has implemented the SSA data file match process afforded under CHIPRA to comply with this requirement. In compliance with Section 211, NCU does not submit deemed newborns to SSA for citizenship verification. For children whose citizenship cannot be successfully verified by the Social Security Administration, Nevada provides applicants a reasonable opportunity period to provide satisfactory documentation of citizenship.

4.1.1 ☒ **Geographic area served by the Plan**: The plan is available statewide, in all 17 Nevada counties.

4.1.2 ☒ **Age:** The plan is available to children 0 through 18 years of age.

4.1.3 ☒ **Income**: Eligible children are from families whose gross annual incomes are at or below 200% of the federal poverty level. Income for the purposes of this plan means gross income before deduction of income taxes, employees' social security taxes, non-health care insurance premiums, bonds, etc. Income includes the:

1. Monetary compensation for services, including wages, salary, tips, commissions or fees;
2. Net income from farm employment;
3. Social Security;
4. Dividends or interest on savings bonds, income from estates or trusts, net rental income, or income from any other source;
5. Government civilian employee or military retirement or pensions or veterans' payments;
6. Private pensions or annuities;
7. Alimony or child support payments;
8. Regular contributions from persons not living in the household;
9. Other cash income. Other cash income includes, but is not limited to, cash amounts received or withdrawn from any source, including savings, investments, trust accounts, and other resources that are readily available to the family; and
10. Unemployment Insurance Benefits.

4.1.4. ☐ **Resources (including any standards relating to spend downs and disposition of resources)**: The Title XXI program has no resource requirements.

4.1.5 ☒ **Residency**: Nevada residency is required. In order to be considered for enrollment in Nevada Check Up, a child must be a citizen of the United States, or be an alien who has legal immigration status. Nevada assures that the term qualified alien is, as defined by Public Law 104-193 as amended, a person who has been in the United States in a qualified alien status for at least five years, or is not subject to the five-year bar

set forth in section 403 of Public Law 104-193. Such a child is eligible for the State Children's Health Insurance Program (SCHIP).

4.1.6. ☒ **Disability Status (so long as any standard relating to disability status does not restrict eligibility)**: No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will be referred to Medicaid and not enrolled in Nevada Check Up.

4.1.7 ☒ **Access to or coverage under other health coverage**: Questions about access to health care coverage, both public and private, are included on the application form. Monthly Third Party Liability cross matches are conducted for verification of health insurance coverage. A child will be found ineligible for the following reasons:

1) He/she has creditable health insurance;

2) He/she is eligible for health benefits coverage under the Public Employees Benefit Program (PEBP) based on a family member's employment with a public agency in the State; or,

3) He/she has had coverage under an employer plan within six months prior to the date of application. The six month waiting period may be waived if the applicant provides evidence that the loss of insurance was due to actions outside the applicant's control. These include insurance coverage that was terminated due to the following reasons:

   a. Loss of employment other than voluntary termination;
   b. Death of the parent who was responsible for insurance coverage;
   c. Change to new employment that does not provide an option for dependant coverage;
   d. Change of address that results in no employer-sponsored coverage;
   e. Discontinuation of health benefits to all employees of the applicant's employer;
   f. Expiration of coverage periods established by the Consolidated Omnibus Reconciliation Act of 1985 (COBRA);
   g. Self-employment;
   h. Termination of health benefits due to a long-term disability;
   i. Termination of dependant coverage due to an extreme economic hardship on the part of either the employee or the employer.
   j. Extreme financial hardship related to the cost of premiums, deductible payments, and/or co-payments.

4.1.8. ☒ **Duration of eligibility**: Once a child has been determined eligible and enrolled, he or she is eligible for up to 12 months of continuous coverage until the annual eligibility redetermination date, no later than one year from the most recent date of enrollment. The child may become ineligible when one or more of the following conditions apply:

1) The child moves out of state;
2) The child becomes enrolled in Medicaid;
3) The child obtains other creditable health insurance;
4) The child turns 19 years old;
5) The child is incarcerated in a penal institution;
6) The child becomes deceased;
7) The child gets married or is ordered a Decree of Emancipation;
8) It has been determined that the child does not meet citizenship requirements and/or the parent/guardian has not provided satisfactory documentation establishing citizenship;
9) The parent/guardian fails to pay quarterly premiums. Please refer to Section 8.7 for a description of consequences for failure to pay premiums timely;
10) The child is a patient (ward of the state) in an institution for mental diseases at the time of initial enrollment or redetermination;
11) During the course of a case review or audit process, it is determined the family provided erroneous information to the state or errors were made in the original determination or redetermination process, resulting in an incorrect eligibility determination;
12) Nevada Check Up (NCU) is requested by the parent/guardian to voluntarily terminate the case;
13) NCU loses contact with the household (is unable to contact the household by mail or phone).

Written notice will be provided to families when the quarterly premium is thirty days past due; Thirty additional days will be allowed to receive payment. Consequently, a sixty day grace period is allowed prior to disenrollment for failure to pay the quarterly premium.

Children can remain in the program annually, if they continue to meet the eligibility criteria.

4.1.9 ☒ Other standards: Social Security numbers are required for children being enrolled in the Nevada Check Up program, except for newborns. Social Security Numbers for newborns will be required on the child's first birthday.

Section 4.1 Subsection

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Child Health Insurance Program
Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards CS14

Section 2101(f) of the ACA and 42 CFR 457.310(d)

☑ Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

○ The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

◉ The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

○ The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.

○ The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.

◉ The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

200 % FPL

○ The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

○ Other.

Describe the benefits provided to this population:

○ This population will be provided the same benefits as are provided to children in the state's Medicaid program.

◉ This population will be provided the same benefits as are provided to children in the state's separate CHIP.

○ Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

○ Cost sharing is the same as for children in the Medicaid program.

CHIP Eligibility

- (●) Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- ( ) No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- ( ) Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42 CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3 ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42 CFR 457.350)

Eligibility is determined through the completion of an application form which includes the following information:

1) Name, date of birth, resident address, gender, Social Security Number, citizenship status, age, ethnicity (optional), and relationship to applicant of all children in the household who are seeking enrollment;
2) Name of person(s) responsible for health care costs of a child;
3) All sources of income as defined in 4.1.3 from all persons residing in the household and contributing to or benefiting from the support of the household;
4) All adults residing in the household;
5) Insurance status, including whether a child is currently or has been insured within the last six months; and
6) If determined eligible: children declared to be citizens will be enrolled.

In addition, the applicant/participant must provide proof of income for each household member. Proof of income may include but is not limited to copies of two current pay stubs from each job dated within 90 days prior to the eligibility determination. For newly hired employees, a signed statement from their employer may be accepted. If self-employed, the applicant may be required to submit a copy of the most recently filed federal/state income tax return.

NCU may accept a client statement of income to determine eligibility for newborns.

Nevada Check Up (NCU) may require additional documentation to determine projected gross annual income from self employment (including but not limited to bank statements and information about household expenses).

The applications are processed and those individuals found eligible are enrolled. If the family is found to have a prior unpaid premium balance, an approval letter is sent requesting the past due balance be paid, at which time the child will be enrolled. For those individuals found eligible without past due balances, an enrollment letter is sent along with an invoice for the first premium (which may be an amount sufficient to

cover one, two, or three months, depending on the date enrollment begins). Program enrollment begins on the first day of the next administrative month.

The enrollment letter includes the following information:

- Household Nevada Check Up ID number;
- Names of eligible children and their ID numbers;
- Name of health plan (Managed Care Organization (MCO) or Fee For Service (FFS));
- Effective month of enrollment; and
- The current amount due and the quarterly premium amount.

Native Americans who are members of federally recognized Tribes and Alaska Natives are exempt from premium payment.

For subsequent eligibility determinations, all children enrolled in the program will stay in the program as long as the family income is below the program maximum and they meet all eligibility requirements. If necessary, the applicant is sent a letter requesting additional or missing information.

Enrollees are required to notify Nevada Check Up immediately with any changes to their address and/or telephone number. Any mail returned indicating the family is no longer at the address may cause disenrollment due to "Loss of Contact".

4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42 CFR 457.305(b))

☐ **Check here if this section does not apply to your state.**

Nevada Check Up will monitor the status of available State and Federal SCHIP funds. An enrollment cap will be placed on the number of new enrollees if it is necessary for the program to stay within available funds. Prior to implementation of an enrollment cap and waiting list, pursuant to NRS 422.2368, the State will provide 30 days of public notice and will conduct a public hearing. The State also will provide notification to CMS.

The enrollment cap may be set above or below current enrollment. If the cap is set below current enrollment levels, enrollment will be closed until the level of the cap is reached. If the cap is set above current enrollment levels, enrollment may continue until the cap is reached, and then enrollment will be closed. Once enrollment is closed, new applications will continue to be accepted through the normal process. NCU eligibility would be run on all applications. The applications of individuals that appear to be eligible for Medicaid would be forwarded to Medicaid for eligibility determination. Those applicants not eligible for Nevada Check Up will be denied with the appropriate reason. The applicants that are eligible for Nevada Check Up but are not able to be enrolled due to the enrollment cap will be denied utilizing the standard program denial process. Their denial reason will be, "denied enrollment due to enrollment cap. These applicants will be notified of the waitlist process. They will also be

notified that their child/ren may be eligible for Medicaid if their circumstances change while they are on the waitlist. They will be put on the wait list with a waitlist date equal to the date when Nevada Check Up received the completed application.

On a monthly basis, Nevada Check Up will make an assessment of the number of enrollees against the appropriated funds for the program. As additional funds become available (either through attrition of enrollees or more funding is identified) a determination will be made as to the number of new enrollees that can be accommodated with the identified funds. The applicants on the wait list will be notified of the availability of coverage. Notification will go out first to those applicants with the earliest wait list date; thus a first come, first served process. To update eligibility, if the update is within the 12 month continuous coverage period, applicants would need to attest that there have not been any changes to their family circumstances (e.g. number in household, income, insurance status, and the like). If changes have occurred, the new information would be added into the Nevada Check Up database and eligibility redetermined. Enrollees determined eligible prior to any enrollment cap will not be impacted by this particular change so long as they continue to pay premiums timely and comply with any requests for information, including income, household, citizenship and identity verification. Enrollees who are disenrolled from the program for failure to timely pay premiums or for failure to timely complete their redetermination process or provide requested information will be precluded from reenrollment during any cap period and will be added to the wait list. These members will receive notice by direct mail informing them of their review rights as required by governing regulations.

4.4. Describe the procedures which assure:

4.4.1. The state explains the procedures used to ensure that children who have other creditable coverage or children who have access to coverage under a State health plan due to a parent's employment with a public agency do not receive coverage under SCHIP.

Nevada Check Up uses screening procedures at intake, annual eligibility determinations, and reevaluations that target low-income children, who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan). Children who are found eligible may receive health benefits under Nevada Check Up. (Section 2102)(b)(3)(A)) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42 CFR 457.350(a)(1)) 457.80(c)(3))

The application contains a screening question asking if the child has had other health care insurance or Medicaid coverage. If the child had past health care coverage, follow up questions are asked as to when and why the coverage ended.

In order to be enrolled in Nevada Check Up, children must have been without creditable insurance for at least six months prior to the date of application. This should provide a disincentive to families to drop current coverage. The exceptions to the six-month waiting period are for children losing Medicaid and for families who lose insurance due to circumstances beyond their control. In those cases, Nevada Check Up coverage would not be a substitution for coverage under group health plans and the six-month "waiting period" does not apply.

In order to ensure that those eligible for coverage under a State health plan are not enrolled in Nevada Check Up, completed applications and income documentation are screened to determine the place and nature of employment. Anyone who is identified as working for an organization listed in the Public Employee Benefit Program employer list and/or those who provide a State agency pay stub and are eligible for benefits based on employment status, are denied coverage.

Nevada Check Up also provides Third Party Liability cross matches on a monthly basis with any participant who has been identified to have other medical coverage. Those participants appear on a report that identifies the policy holder, the policy carrier, effective dates of coverage and the policy type. This information is used to disenroll the participants who have other medical coverage and are receiving Nevada Check Up benefits.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42 CFR, 457.350(a)(1) and 457.80(c)(3))

In order to assure that Medicaid eligible children are enrolled in Medicaid, Nevada takes the following steps:

1) The Nevada Check Up application functions as both an application for Nevada Check Up and a pre-screening tool for Medicaid eligibility. Nevada Check Up screens all initial applications, redeterminations and reevaluations for Medicaid through the use of an electronic screening tool that determines if a child may be eligible for Medicaid.
2) The Nevada Check Up application asks whether the application is to be considered as a referral to Medicaid. If the applicant selects "no" and appears to be Medicaid eligible, Nevada Check Up will deny coverage in writing without referring the applicant to Nevada State Division of Welfare and Supportive Services (DWSS) for a Medicaid eligibility determination.
3) If the applicant selects "yes" and the child appears to be eligible for Medicaid based on the results of the screening tool, coverage is denied for Nevada Check Up and a referral is made to DWSS for an eligibility determination for Medicaid.

4) Nevada Check Up enrollees are electronically screened daily to ensure that children are not enrolled in both Nevada Check Up and Medicaid.
5) Nevada Check Up also monitors referrals to DWSS to ensure timely Medicaid determinations.

4.4.3 The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Section 2102(a)(1) and (2) and 2102(c)(2)) (42 CFR 431.636(b)(4))

A file containing detailed information about children who have been found ineligible for Medicaid is provided electronically to the Nevada Check Up program. This file will provide information on children who appear to meet the eligibility requirements for Nevada Check Up. This information is uploaded electronically into the Nevada Check Up database and these children are enrolled on the first day of the next administrative month following eligibility verification. At the same time the family is notified of eligibility, they are billed for the Nevada Check Up premium, including a date by which premium must be paid.

Children already enrolled in Nevada Check Up who are subsequently **placed in the custody or financial responsibility of an agency which provides child welfare services pursuant to the provisions of NRS 62A.380 or 432.010 to 432.085, inclusive, or Chapter 432B of NRS** are disenrolled and made eligible for Medicaid. Once the child is returned home, the household must notify Nevada Check Up of his/her residency status in order to re-enroll the child.

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42 CFR 457.805) (42 CFR 457.810 (a) – (c))

4.4.4.1. Coverage provided to children in families at or below 200% FPL
Describe the methods of monitoring substitution.
Persons covered by insurance providing hospital and medical services are not eligible for benefits under Nevada Check Up. In order to apply for Nevada Check Up, children are required to have been without creditable insurance for at least six months prior to the date of enrollment. (Certain exceptions apply as noted in 4.1.7 and also include those whose only coverage was Medicaid) The Nevada Check Up application form includes a question regarding other insurance coverage within the last six-month period. The State gathers information on a monthly basis on the number of applicants who were denied because they had other insurance coverage in the last six months. This provides a disincentive to families to drop current coverage. Caseworkers review the applicants' pay stubs to determine if dependant premiums are being deducted by the employer.

The Division of Health Care Financing and Policy (DHCFP) monitors overall health insurance coverage for children and determines additional steps to be taken if substitution (crowd out) appears to be taking place. When applicants indicate they have had previous coverage within the past six months, there is further screening to determine the circumstances by which that coverage ended. The fiscal agent and the Managed Care Organizations screen claims for other insurance coverage and inform Nevada Check Up if other insurance is found, in which case a disenrollment notice is sent for the next administrative month.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4 ☐ If the state provides coverage under a premium assistance program, describe: The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period. The minimum employer contribution. The cost effectiveness determination.

4.4.5. Child health assistance is provided to targeted low-income children in the state who are Native American and Alaska Native (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

Native American and Alaska Native children are provided the same opportunity for enrollment as all other children. These families are exempt from cost sharing.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish: Outreach to families of children likely to be eligible for assistance or other public or private health coverage to inform them of the availability of the programs and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42 CFR 457.90)

Nevada Check Up conducts multi-faceted outreach and referral efforts to inform families of the availability of state sponsored health care coverage for children under both Nevada Check Up and Medicaid. These efforts are supported by the Northern and Southern Covering Kids and Families Coalitions' outreach efforts as well as other community partners.

Nevada has established a toll free telephone number for people who want an application form mailed. The number is also used for providing assistance in completing the application and answering questions about the program.

Assistance in Enrolling Children

The most important "assistance" provided is the use of a simple application form which enables most parents to submit applications without direct help. Community-based organizations are trained to assist families in filling out the application and answer questions applicants may have about the program.

Nevada Check Up also has an internet website which includes applications in English and Spanish for downloading. Families can print this application, complete it and mail to Nevada Check Up with the necessary additional documents. The website also includes an on-line application which can be completed and submitted electronically. The family is required to mail the income verification and other required documentation to be matched with the internet application.

In the future, through collaboration with the DWSS, there will be a joint Welfare/Medicaid/Nevada Check Up electronic application. At the present time, budget constraints have placed this project on hold.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

Nevada Check Up is not reducing or limiting benefits in this response.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.)

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1)) and 42 CFR 457.420)

6.1.1.1.☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2.☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3.☐ HMO or MCO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4)**.** See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. (Section 2103(a)(4)) In adopting the State's Medicaid plan (with the differences listed in Section 2.1);

6.1.4.1 ☐ Coverage the same as Medicaid State plan
6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5.☐ Coverage that is the same as defined by an existing comprehensive state-based coverage

6.1.4.6.☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7.☒ Other (Describe) Coverage the same as Medicaid State Plan with the exception of non-emergency transportation. Payment differences are listed in Section 2.1.

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42 CFR 457.490)

There are no co-payments or deductibles for any of the Nevada Check Up covered services below:

6.2.1. ☒ **Inpatient services** (Section 2110(a)(1))
Inpatient services include all physician, surgical and other services delivered during a hospital stay. Inpatient services covered in full.

6.2.2. ☒ **Outpatient services** (Section 2110(a)(2))
Outpatient services include outpatient surgery – covered in full.

6.2.3. ☒ **Physician services** (Section 2110(a)(3))
Physician services include medical office visits with a physician, mid-level practitioner or specialist. Covered in full. Preventive care (well baby) and immunizations covered in full.

6.2.4. ☒ **Surgical services** (Section 2110(a)(4))
Covered in full. See 6.2.1 for inpatient surgical services and 6.2.2 for outpatient surgical services.

6.2.5. ☒ **Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))**
See section 6.2.2.

6.2.6. ☒ **Prescription drugs (Section 2110(a)(6))**
Covered for inpatient and outpatient prescription drugs with no co-payment.

6.2.7. ☒ **Over-the-counter medications (Section 2110(a)(7))** Over-the-counter medications are covered when prescribed by an authorized medical provider. The participant may have up to two over-the-counter medications within a therapeutic class before a prior authorization is required.

6.2.8. ☒ **Laboratory and radiological services (Section 2110(a)(8))**
Covered in full for physician-ordered services.

6.2.9. ☒ **Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))**
Family planning and prenatal maternity care covered in full.

6.2.10. ☒ **Inpatient mental health services, other than services described in 6.2.18., but not including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))**

Services covered with continuing stay authorized by Quality Improvement Organization (QIO) like vendor. All covered treatment consistent with Medicaid Services Manual, Chapter 400.

6.2.11. ☒ **Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)**

Mental health professionals are subject to the following utilization criteria: Utilization criteria is based on the Intensity of Needs Determination. A standardized mechanism to determine the intensity of services needed based upon the severity of the recipient's condition. The intensity of needs determination is to be utilized in conjunction with the clinical judgment of the Qualified Mental Health Professional (QMHP) and/or trained Qualified Mental Health Associate (QMHA). This assessment was previously known as a level of care assessment. Currently, DHCFP recognizes the Level of Care Utilization System (LOCUS) for adults and the Child and Adolescent Screening Intensity Instrument (CASII) for children and adolescents. There is no level of care assessment tool recognized by DHCFP for children below age six, however, providers must utilize a tool comparable to the CASII and recognized as a standard of practice in determining the intensity of needs for this age group.

6.2.12. ☒ **Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))**

Durable medical equipment is dispensed, on prescription signed by a physician or physician extender (APN, PA), based on medical necessity and prior authorization. There are limitations which may only be overridden by authorized approval of written, medical justification.

6.2.13. ☒ **Disposable medical supplies (Section 2110(a)(13))**

6.2.14. ☒ **Home and community-based health care services (See instructions) (Section 2110(a)(14))**

6.2.15. ☒ **Nursing care services (See instructions) (Section 2110(a)(15))**

Skilled nursing covered with no limitations as long as medical necessity requirements have been met.

6.2.16. ☒ **Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)**

6.2.17. ☒ **Dental services (Section 2110(a)(17))**

Coverage for preventive, diagnostic and treatment, and other general dental services and emergency assessments. Medically necessary orthodontia is a benefit requiring prior authorization.

6.2.-D ☒ The State will provide dental coverage to children through one of the following. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)(c)):

6.2.1-D ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays (CDT codes: D0100-D0999) (must follow periodicity schedule).
2. Preventative (i.e., dental prophylaxis, topical fluoride treatments (CDT codes: D1000-D1999) (must follow periodicity schedule).
3. Restorative (i.e. fillings, crowns) (CDT codes: D2000-D2999).
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999).
5. Periodontic (treatment of gum disease (CDT codes: D4000-D4999).
6. Prosthodontic (dentures) (CDT codes: D5000-5899 and D5900-D5999, D5900-D5999, and D6200-D6999).
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orhtodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.2-D☐ Periodicity Schedule. The State has adopted the following periodicity schedule:

☒ State-developed Medicaid-specific
☐ American Academy of Pediatric Dentistry
☐ Other Nationally recognized periodicity schedule
☐ Other (description attached)

6.2.2-D☐ Benchmark coverage (Section 2103(c)(5), 42 CFR 457.410, and CFR 457.420)

6.2.2.1-D☐ FEHBP – equivalent coverage (Section 2103(c)(5)(C)(i))(If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)

6.2.2.2-D☐ State employee coverage (Section 2103(c)(5)(C)(ii))(If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)

6.2.2.3-D☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description of the services and applicable CDT codes.)

6.2.18. ☒ **Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))**
Detoxification – Limited to 5 hospital days, more if medical necessity warrants. Treatment – Limited to 21 hospital days, more if medical necessity warrants.

6.2.19. ☒ **Outpatient substance abuse treatment services (Section 2110(a)(19))**
The benefit is the same as 6.2.11 above.

6.2.20. ☒ **Case management services (Section 2110(a)(20))**
Targeted case management services are required to be provided by the Nevada Check Up program, consistent with the Medicaid Title XIX State Plan.

6.2.21. ☒ **Care coordination services (Section 2110(a)(21))**
Care coordination services are required to be provided by the MCOs in the managed care portion of the Nevada Check Up program. Care coordination services are not currently available in the fee-for-service areas.

6.2.22. ☒ **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))**
Therapy Services, including group and individual treatment, are subject to utilization management criteria.

6.2.23. ☒ **Hospice care (Section 2110(a)(23))**
Inpatient covered for up to six months; subsequent periods may be approved in 30-day blocs. Hospice may also include routine or continuous home care, respite care, counseling, appliances, supplies and pharmaceuticals. Curative services are provided to NCU participants in accordance with section 2302 of the Affordable Care Act.

6.2.24. ☒ **Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))**
Annual vision screening exam and glasses, hearing exams, medically necessary transplants as required under the title XIX EPSDT program.

6.2.25. ☐ **Premiums for private health care insurance coverage (Section 2110(a)(25))**

6.2.26. ☒ **Medical transportation (Section 2110(a)(26))**
Hospital and emergency room transport are covered.

6.2.27. ☒ **Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))**

6.2.28. ☐ **Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))**

Benefits are subject to prior authorization and/or other utilization review controls as established by the plan, except for emergency services. For areas not covered by an MCO, a fee for service benefit is provided with the same State Plan benefit package.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR457.480)

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**

6.3.2 ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan, to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*

6.4 Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1.☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (**Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.**

7.1 Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42 CFR 457.495(a))

The DHCFP performs the same readiness review process, less those issues which are specific to Medicaid, prior to allowing the MCO contractor to deliver services under the Nevada Check Up program.

Overall program monitoring to assure quality and appropriateness of care will be performed on an ongoing basis by the following activities:

1) Review and analysis of encounter and financial data;
2) Review of participant and provider complaints and grievances filed with the State Insurance and/or Health Division;
3) The compilation, review and investigation, where warranted, of consumer satisfaction data; and
4) Establishment of quality and performance measures for well baby care, well child care, and immunization monitored through encounter data and chart review.

Contract monitoring is performed through the following actions:

1) Annual quality and operational review of each contractor;
2) Identical encounter data reporting (in form, format, and periodicity) as required under the Medicaid Managed Care program (to the extent that such services are program benefits under the contract);
3) Review of the contractors and contract data by an External Quality Review Organization (EQRO);
4) Generation of Health Plan Employer Data and Information Set (HEDIS) reporting, depending on program benefits under the contract, with the same periodicity, form and format as under the Medicaid Managed Care program;
5) Performing on-site review, if problems of a material nature arise;
6) Performance of a yearly member satisfaction survey by DHCFP and/or the MCO contractors with review, analysis and follow-up (as required) by the State.
7) Complaints filed by enrolled participants with the MCO plans. Participating plans are contractually required to report complaints on a quarterly basis. These reports are shared with enrolled participants who request the information. In addition, DHCFP will track the information on the number and type of complaints filed by participants enrolled in a plan. Complaint information is used by DHCFP to identify plan performance needing improvement and to form the basis of future performance standards.

8) DHCFP works with the state's two health insurance industry regulatory entities (i.e., the Division of Insurance and the Health Division) to ensure all publicly available data on health plan performance is known to DHCFP.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1 ☒ Quality standards

The state utilizes quality standards for the Nevada Check Up program identical to those currently used under the Medicaid Managed Care Program.

The following clinical areas of concern are monitored:

1. Comprehensive Well Baby and Well Child Periodic Health Screening

   Standard
   Well Baby/Well Child screenings comprise a comprehensive health and developmental history, unclothed physical exam, and vision, dental, and hearing evaluations with follow-up. When indicated appropriate diagnostic and treatment services must be provided. Periodic screening will be completed on behalf of all eligible children between the ages of 0 through 18, according to the most current HEDIS guidelines.

   An interperiodic screening is one which is provided at medically necessary intervals to determine the existence of physical or mental illnesses or conditions of concern, or to follow up on previously diagnosed health problems. Such screening exams must be provided at the request of a parent, guardian, health, or educational professional.

2. Childhood Immunizations

   Standard
   Age appropriate immunizations will be documented in the medical record unless documentation is provided of exemption due to State law. Age appropriate immunizations required by the State are those recommended by a recognized medical academy and/or required by the Centers for Medicare and Medicaid Services (CMS) The MCO is responsible for implementing the most recent immunization schedule as endorsed by the American Academy of Pediatrics and the Nevada Health Division.

3. Family Planning

   Standard
   Family planning services are provided to Nevada Check Up eligible children, both male and female, of child bearing age.

4. Dental Services

   Standard
   Dental services (including medically necessary orthodontia, if prior authorized) are provided to Nevada Check Up eligible participants.

5. Medical Record Standards

   Standard
   The MCO must maintain medical records in accordance with Standard XII of the "Guidelines for Internal Quality Assurance Programs" as set forth in the CMS Medicaid guidelines.

6. Appointment Standards

   Standard
   90% of appointments must meet time criteria (both for waiting and for number of days between request and appointment).

7.1.2 ☒ Performance measurement

Performance measurements for each of the Quality Standards noted in 7.1.1 are similar to or the same as those currently utilized in the Medicaid Managed Care program.

1. Comprehensive Well Baby and Well Child Periodic and Interperiodic Health Assessments - Periodic screening

   A. Measurement
      1) 80% of Nevada Check Up eligible children who are enrolled for 12 months must have an age appropriate periodic screening. HMO or MCO compliance is monitored by a quarterly evaluation of encounter data and, if indicated, liquidated damages will be calculated based on the initial annual review; that is, twelve (12) months of the contract year.

      Liquidated Damage: (number of required Periodic screenings not completed) x (Periodic screening fee) = liquidated damage.

      2) Annually, a chart sample of Nevada Check Up eligible children will be reviewed. During chart review, areas of critical concern are age appropriate developmental, dental, vision and hearing screenings with follow-up when indicated by diagnostic and treatment activities and/or referrals. The timely scheduling and completion of interperiodic screening upon request, accompanied by necessary follow-up activities, will be assessed during the chart review.

Corrective action: If chart reviews suggest poor quality of medical care and/or inadequate follow up activities and treatment, DHCFP may direct the MCO to conduct a study of particular areas of concern. In cases of immediate concern, a simultaneous referral to the Division of Insurance and the Health Division may be initiated for further examination of appropriateness and quality of care within the existing scope of each agency.

B. Method
Encounter data, chart review, analysis of number and nature of complaint reports, and participant/guardian surveys are analyzed and evaluated.

C. Frequency
DHCFP will generate quarterly reports from encounter data with an annual cumulative report. An annual on-site review with an emphasis on chart review will be conducted by DHCFP and/or an EQRO. Chart review may be conducted more often than annually, if indicated by encounter data, complaints, etc.

2. Childhood Immunizations

A. Measurement
Documentation showing 90% of Nevada Check Up eligible non-exempt participants, ages 0 through 2 are appropriately immunized. Documentation showing 95% of Nevada Check Up eligible non-exempt participants, ages 3 through 18 are appropriately immunized. Nevada Check Up clients must have been enrolled for 12 months before compliance with required percentages is calculated. For tracking purposes in managed care, each immunization (vaccine) will include two encounter codes. One code will indicate administration of a specific vaccine; the second code will indicate a history of receiving a specific immunization.

An action plan will be required from the MCO if compliance is less than 90% for children ages 0 through 2 and/or less than 95 % for those who are ages 3 through 18.

B. Method
Encounter data, chart review, and analysis of number and nature of complaints reported.

C. Frequency
DHCFP generates quarterly reports from encounter data with an annual cumulative report. An annual review is conducted by DHCFP and/or an EQRO.

3. Family Planning

A. Measurement
80% of eligible participants of child bearing age receive age appropriate education and services regarding family planning. A chart sample of participants who are enrolled for at least 6 months will be reviewed for compliance. At a minimum, documentation indicating that family planning information was offered or provided must be evident in the participant's record. An action plan is required if the percent of compliance is less than 80%.

B. Method
Encounter data, chart review and verification of service from participants whose records were reviewed will be evaluated; analysis of number and nature of complaints reported, and participant/parent/ guardian surveys will be analyzed and evaluated.

C. Frequency
DHCFP will generate quarterly reports and an annual cumulative report utilizing encounter data submitted by the MCO. DHCFP will conduct an annual review. If the reviewed sample does not meet the minimum percentage criteria, follow-up will be conducted by DHCFP staff.

4. Dental Services

A. Measurement
20 percent of Nevada Check Up participants, ages 3 to 5, who have been enrolled at least twelve (12) months will receive at least one oral health screening, referral and follow-up for necessary diagnostic and preventive services; and, 50 percent of participants, ages 5 to 18, who have been enrolled for twelve (12) months will receive at least one dental visit in the reporting year.

B. Method
Encounter data, chart review and verification of service from participants whose records were reviewed will be evaluated. An analysis of the number and nature of complaints reported, with the participant/parent/guardian surveys will be analyzed and evaluated.

C. Frequency
DHCFP will generate quarterly reports and an annual cumulative report utilizing encounter data submitted by the MCO. DHCFP will conduct an annual review. If the reviewed sample does not meet the minimum percentage criteria, follow-up will be conducted by DHCFP and/or EQRO staff.

5. Appointment standards

A. Measurement

1) Appointments with primary care providers (PCP):

The MCO shall have procedures in place that ensure:

(a) Same day primary care provider appointments for symptoms which are of sudden or severe onset but which do not require emergency room service are available;
(b) Urgent care PCP appointments are available within two calendar days; and,
(c) Routine care PCP appointments are available within two weeks. This two-week standard does not apply to regularly scheduled visits to monitor a chronic medical condition, if the schedule calls for visits more frequently than once every two weeks.

2) Specialty appointments

For specialty referrals to physicians, therapist and other diagnostic and treatment health care providers the MCO shall provide:

(a) Same day appointments within twenty-four hours of referrals as in 1) (a) above;
(b) Urgent care appointments within three calendar days of referral; and,
(c) Routine appointments within two weeks

3) Dental Appointments

(a) Initial appointment to a dentist is available within four weeks;
(b) Follow up appointments according to a plan of care within two weeks;
(c) Urgent care appointments within one week; and
(d) Emergency care (severe tooth ache, loss of tooth) within 24 hours.

4) Office Waiting Times

The MCO plans shall monitor and ensure that a participant's waiting time at the PCP or specialist's office is not more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency. Office waiting times may be delayed when they "work in" urgent cases, when a serious problem is found, or when the patient had an unknown need that requires more services or education than was described at the time the appointment was made.

A Plan of Correction (POC) will be required if the 90% Standard is not met.

a. Method
DHCFP and/or an EQRO will validate this annually by means of on-site observations, chart reviews, enrollee satisfaction surveys, review of grievances, and interviews with enrollees.

b. Frequency
DHCFP and/or the EQRO will conduct reviews of available data at least annually.

6. Medical Records Standards

A. Measurement
Of the 16 elements of medical record keeping, nine are critical and must be present in each record. The critical items for medical record keeping are as follows: 1) patient identification information; 2) personal/biographical data; 3) entry date; 4) provider identification; 5) legibility; 6) allergies; 7) immunizations; 8) medication information; and 9) identification of current problems.

A sample of the MCO's Nevada Check Up participants' medical records will be reviewed: 90% of records reviewed must contain medical record keeping and patient visit data items indicated as critical. An action plan will be required if the percent of standard is less than 90%.

B. Method
Medical records will be reviewed.

C. Frequency
Record reviews will be conducted annually by DHCFP and /or an EQRO. If the reviewed sample does not meet the minimum criteria, a corrective action plan will be required from the MCO and follow-up will be done by the DHCFP staff.

(Please note that the specific standards may be altered as a result of contract negotiations.)

7.1.3 ☒ **Information strategies**

A new one-step application and enrollment process is being developed and was implemented as of July 2003. At the time of application completion, the head of household must choose a health plan from information provided on the application. Nevada Check Up eligibility specialists enters the MCO or fee-for-service information while determining eligibility.

Nevada Check Up enrolled families receive a handbook from their chosen health plan which describes the benefits provided to enrollees under the program. These materials also describe enrollee rights and responsibilities and the specific steps to file a complaint.

DHCFP will collect information from the health plans on a quarterly and annual basis. This reporting provides information on enrollment, demographics, ethnic characteristics, outreach efforts, use of medical and dental services, enrollee grievance information, and data on financial expenditures. Information is used by DHCFP to document performance and assure adequate program accountability.

The Division, MCO and/or the External Quality Review Organization (EQRO) will conduct yearly consumer satisfaction surveys no more than three months after the end of the first year of the contract and every year thereafter. This data is compiled and analyzed. Where areas of concern exist, an audit will be performed and if the area of concern is valid, the MCO will be required to produce a plan of correction as is currently required under the Medicaid Managed Care program.

7.1.4. ☒ **Quality improvement strategies**

Quality improvement strategies, with which the MCO contractor must comply, are as follows:

1) Requirements for written policies and procedures regarding prior authorization standards and criteria, and for periodic review and updating of said policies and procedures;
2) Policies and procedures regarding utilization review activities, including reports to state agencies on methods from reviewing, and follow-up activities required based on the outcome of the review activities;
3) Establishment (including requirements) of a quality assurance program designed to direct, evaluate and monitor the effectiveness of health care services provided to its enrollees. The program must include, as defined in the Nevada Statutes, without limitation:
    a) A method for analyzing the outcomes of health care services;
    b) Peer review;
    c) A system to collect and maintain information related to the health care services provided to enrollees;
    d) Recommendations for remedial actions; and
    e) Written guidelines that set forth the procedures for remedial action when problems related to quality of care are identified.
4) Corrective action plans will be required as indicated above, where quality standards, consumer satisfaction surveys or performance measurements are below those stated standards;
5) In severe or blatant cases of non-compliance, the Division will assess liquidated damages for not meeting performance measures.

7.2.1 Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42 CFR 457.495)

7.2.1. Access to well-baby care, well-adolescent care and childhood and adolescent immunizations. (Section 2102 (a) (7)) (42 CFR 457.495 (a)). Refer to Section 7.1.1., item 1. & 2. Section 7.1.2., item 1. & 2.

All Nevada Check Up participants are encouraged to seek well-baby and well-child care. The MCO contracts contain standards for well-baby and well-child visits at not less than the national baseline average, along with the immunizations recommended in section 7.1.1., number 2. The contract standards include establishing, maintaining, and reporting on records of these visits and immunizations. They are also required to send out reminder notices to families that a well-child check or immunization is due. FFS providers are expected to comply with the American Academy of Pediatrics periodicity schedule for well-baby and well-child care purposes.

The Medicaid Managed Care contract requires that HEDIS measurements be used to evaluate an MCO's performance. The MCO's HEDIS immunization measurement rates must be comparable to the HEDIS National Medicaid average. The contract includes provision for development of corrective action plans if performance is not adequate.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102 (a) (7)) (42 CFR 457.495 (6))

Emergency Services: The MCOs cannot require participants to seek prior authorization for services in a medical or behavioral health emergency. MCOs must inform their enrollees that access to covered emergency services is not restricted and that if the participant experiences a medical or behavioral health emergency, he/she may obtain services from a non-plan physician or other qualified provider without penalty. However, health plans may deny payment for such a visit should the visit be determined as a non-emergency using a prudent lay person standard. The health plan may require members to obtain prior authorization for any recommended or requested follow-up care pursuant to the emergency.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102 (a) (7)) (42 CFR 457.495 (c)). Refer to Section 7.1.1., item 6. and Section 7.1.2., item 5.

Service Accessibility: The MCO must take measures to ensure compliance with the access standards. DHCFP monitors MCO performance and will take action if problems are identified.

Access to care analyses will be based on the results of participant satisfaction surveys participant complaint data, and appointment scheduling. The number of participants enrolled will be used to determine the adequacy of the MCO's panel of PCPs and specialists.

The contract with managed care providers requires that their Enrollee Services Departments assist enrollees in obtaining out-of-area and out-of-network care. The children in Nevada Check Up's fee-for-service component are free to seek services from any Medicaid provider in the state. Out-of-state and out-of-network providers will be accepted if they are willing to abide by the terms of Nevada Check Up claims payment rates and processes. The participants enrolled in fee-for-service have more direct access to specialists and out-of-state providers in that their care is directed by their primary care physicians who will often make referrals for the participants. The Medicaid district offices will also assist Nevada Check Up families with access to care.

Twenty-four (24) Hour Coverage: The MCO must provide health care coverage to its members, twenty-four (24) hours a day and seven (7) days a week. The MCO must instruct their enrollees how to obtain services after business hours and on weekends.

Telephone Access: The MCO may require their PCPs to have primary responsibility for serving as after hours "on-call" telephone resources to members with medical problems. Whether or not the plan assigns primary responsibility for after hours telephone access to a PCP, it must have a twenty-four (24) hour toll free telephone number for members to call, which must be answered by a live person.

Days to Appointment: The MCO must abide by the following appointment standards:

- Urgent medical or behavioral problems within 24 hours;
- Non-urgent "sick visits" within 48 hours, as clinically indicated;
- Routine, non-urgent or preventive care visits within two weeks: and
- In-plan, non-urgent mental health or substance abuse visits within two weeks.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after receipt of request for services (Section 2102 (a) (7)) (42 CFR 457.495 (d))

State licensed MCOs are the principal health plan providers for enrollees who reside in areas served by managed care. Under Nevada Revised Statute 695C, these entities are subject to oversight and regulation by the Division of Insurance (DOI). The DOI is primarily responsible for monitoring initial capitalization and financial solvency. The Health Division is charged with

monitoring quality of care and assuring the availability of and accessibility to health services.

Requests for prior authorization are within the purview of this section. The MCOs are allowed a maximum of 14 days from the date of receipt of the request to provide an answer. In accordance with Title 42CFR 457.495(d)(1), there is allowance for an additional 14 days if the participant requests an extension or if the health care provider determines additional information is needed. Nevada Check Up fee-for-service prior authorization requests are processed by the fiscal agent and are completed in the same manner and time frames as are required for Medicaid.

To obtain licensure, certain requirements regarding availability and access must be satisfied by an MCO. These requirements are:

- Coverage for basic health services, including emergency services;
- Provisions for access to primary care physician for each subscriber;
- Evidence of arrangements for the ten most commonly used specialists;
- Policies on obtaining referrals for specialty care;
- Physician and provider network capacities.

Many of these requirements are evaluated: initially upon licensure; upon request for service area expansion; and periodically through complaint and grievance monitoring; and on-site visits by both Divisions.

To participate in the Nevada Check Up program, MCOs must establish and maintain provider networks with sufficient number of providers in each contracted geographic service area. The MCOs' networks must contain all provider types necessary to provide to its enrollees a continuum of services which includes primary and preventive care and includes the diagnosis, management and treatment of a variety of diseases and conditions, as well as specialized care to handle complex health problems. The MCO must include the provider types necessary to furnish the prepaid benefit package, including: hospitals; physicians (primary care and specialists); mental health and substance abuse providers; nursing homes; and pharmacies. If an MCO is unable to provide the medically necessary covered service within its provider network, it must allow the participant to obtain the service through an out-of-network provider. The MCO must facilitate the referral to an out-of-network provider on behalf of the enrollee and must reimburse the out-of-network provider at not less than the Medicaid FFS rate for the covered service. MCOs shall not include in their networks any medical provider who has been sanctioned by Medicare or Medicaid.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the states Medicaid plan, and continue on to Section 9.**

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. ☒ YES
8.1.2. ☐ NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing and any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A))(42CFR 457.505(a), 457.510(b) & (c), 457.515(a) & (c))

8.2.1. Premiums: A quarterly premium is charged per family based on gross income, except for American Indians who are members of federally recognized Tribes and Alaska Natives, who are exempt from premiums. Starting April 1, 2008, families whose incomes are at or above 176% of FPL, the premium is $80 per quarter ($320 per year). For families whose incomes are at or above 151% FPL but at or below 175% FPL, the premium is $50 per quarter ($200 per year). For families whose incomes are at or above 36% FPL up to 150% FPL, the premium will be $25 per quarter ($100 per year) and these families are offered the option of paying their premium monthly, rather than quarterly. For families whose incomes are below 36% FPL, the premium is zero. These enrollees are either Medicaid referrals or have assets that would preclude their enrollment in Medicaid.

Families whose incomes are at or below 150% FPL are notified on the premium notice that Nevada Check Up premiums may be paid on a monthly basis.

8.2.2. Deductibles: There are no deductibles.

8.2.3 Coinsurance: There is no coinsurance

8.2.4 Other**:**

8.3 Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to those amounts and any differences based on income: (Section 2103(e)) ((1)(B)) (42 CFR 457.505 (b))

The cost sharing information is explained to potential enrollees through the application, which includes a chart of income eligibility and premium payment amounts on its cover. If changes are necessary to the cost sharing requirements of Nevada Check Up, all current enrollees are notified by letter of the changes and effective dates. Public hearings are held to allow the public to comment on any proposed changes to cost sharing in Nevada Check Up.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)

8.4.2. ☒ No additional cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)

8.4.3. ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103 (e) (1) (A)) (42 CFR 457.515 (f))

8.5 Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a referral given by the State for overpayment by an enrollee: (Section 2103 (e) (3) (B)) (42 CFR 457.560 (b) and 457.505 (e))

The cost sharing requirements are set at very low levels so it is extremely unlikely that any families over 150% of FPL could approach the 5 percent cap. For a family of two at 150% of FPL, the 5 percent cap is $994 ($19,898 x .05); the total Nevada Check Up annual premiums are $100. For a family of two at 166% of FPL, the 5 percent cap is $1,101 ($22,020 x .05); the total Nevada Check Up annual premiums are $200. For a family of two at 200% of FPL, the 5 percent cap is $1,327 ($26,531 x .05); the total Nevada Check Up annual premiums are $320.

To further illustrate how low Nevada Check Up's premium amounts are, a family of two with income of $13,265 is at 100% FPL and, if eligible for enrollment in Nevada Check Up, would pay $100 each year in premiums, less than 1% of their income. The maximum allowed for SCHIP cost sharing in this case is $663 per year. At the extreme low level (36% FPL) of those charged premium fees, the 5% cap equals $239 annually and Nevada Check Up premium totals $100.

The State does not impose any other co-payment or deductible.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. (Section 2103 (b) (3) (D)) (42 CFR 457.535)

The instructional section of the application states that premiums are waived for any household with an American Indian or Alaska Native child. Additionally, the application includes an ethnicity question and through self declaration, the family indicates each child's ethnicity. This information is utilized to derive the premium notices. The Nevada Check Up database includes an edit to set the premium amount to zero if an American Indian or Alaska Native child is in the household.

8.7. Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR 457.570 and 457.505 (c))

The applications will be processed and those found eligible are enrolled subject to a full enrollment limitation. Written notice will be provided to families, no later than 7 days after the start of the grace period, when the quarterly premium is past due; additionally a final notice indicating disenrollment will be sent 30 days prior to the potential disenrollment action. (Notices generate at system cutoff approximately 5 days prior to the end of the month and are mailed the next day allowing at least 30 days notice) If payment is not received prior to the intended disenrollment date the children will be disenrolled at the end of the two month grace period. All past due balances must be paid prior to new enrollment. (i.e. Premium request for January/February/March (new coverage period) is mailed November 29, 2011. If payment not received, late notice mailed December 7, 2011. No payment, final notice mailed January 24, 2012, indicating termination effective February 29, 2012. If payment is received by February 24, 2012, coverage will continue.)

American Indians who are members of federally recognized Tribes and Alaska Natives are exempt from paying premiums.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, co-payments, coinsurance, deductibles, or similar fees prior to disenrollment. (42 CFR 457.570 (a))
  - Participating families are always given 30 days written notice of any action that will result in their disenrollment from Nevada Check Up.
- ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42 CFR 457.570 (b))
  - Families who receive notices of impending disenrollment are encouraged to respond with documentation that will assist eligibility staff to modify their premium and allow their continued enrollment in Nevada Check Up.
- ☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42 CFR 457.570 (b))
  - Nevada Check Up denies enrollment and refers all children to Medicaid who appear to be Medicaid eligible at the time of application. Families who are Medicaid eligible must apply for Medicaid and cooperate with the Medicaid eligibility process. These families are not considered for enrollment in Nevada Check Up until any Medicaid questions have been resolved and/or their circumstances change with the result that they are no longer Medicaid eligible. Cost sharing is always adjusted based on family income.

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570 (c))

- Nevada Check Up letters always include information on how to request a review of any decision that impacts the family's enrollment.

8.8. The state assures it has made the following findings with respect to the payment aspects of its plan: (Section 2103 (e))

8.8.1. ☒ No Federal funds will be used toward state matching requirements. (Section 2105 (c)(4)) (42 CFR 457.220)

- DHCFP ensures that no Federal funds accounts for in any way to make them appear as if they were part of a state match.

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105 (c) (5)) (42 CFR 457.224)

- Cost sharing funds received by Nevada Check Up are used only to defray administrative costs of the program.

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title. (Section 2105 (c)(6)(A)) (42 CFR 457.626 (a)(1))

- Nevada Check Up does not provide insurance to families who have private insurance or have access to affordable private insurance.

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105 (d)(1)) (42 CFR 457.622(b)(5))

- Medicaid eligibility is determined by DWSS eligibility specialists and is in compliance with Federal standards.

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105 (c)(7)(B)) (42 CFR 457.475)

- DHCFP assures that abortion coverage is only that which complies with the rules set forth in the citations listed above.

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105(c)(7)(A)) (42 CFR 457.475)

- DHCFP assures that abortion coverage is only that which complies with the rules set forth in the citations listed above.

Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42 CFR 457.710 (b))

The strategic objectives for the Nevada Check Up program are to:

1. Increase the availability of comprehensive low cost health coverage for children at or below 200% FPL, and not eligible for Medicaid.
2. Provide an application and enrollment process which is easy for targeted low income families to understand and use.
3. Improve accessibility to dental providers for children enrolled in Nevada Check Up.
4. Through the administration of the Covering Kids and Families grant, assure the participation of community-based organizations in outreach and education activities.
5. Assure a high degree of participant satisfaction with the Nevada Check Up program.

9.2 Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42 CFR 457.710(c))

The following performance goals and measures will be used to evaluate the program's effectiveness:

1.1 Increase the percentage of children enrolled in Nevada Check Up by 5% annually, thus decreasing overall uninsured child rates in Nevada.

1.2 Process applications and enroll Nevada Check Up applicants within 30 days from the date the application is received.

2.1 Provide timely application completion assistance through dial up telephone support in both English and Spanish.

2.2 Simplify the Nevada Check Up application from a two-step to a one-step process.

2.3 Create and implement an annual quality improvement review of the Nevada Check Up business processes.

3. Achieve year to year improvements in the percentage of targeted low income children that have had a visit with a dental provider during the year.

4.1 Achieve effective outreach and education activities by community-based organizations in collaboration with Covering Kids and Families.

4.2 Achieve annual increases in the number of outreach and education activities for Nevada Check Up provided by community-based organizations in collaboration with Covering Kids and Families.

4.3 Increase school-based outreach programs in the State of Nevada, resulting in an increase in the number of Nevada Check Up applications submitted that are directly attributable to school-based outreach activities.

5. Achieve a high degree of satisfaction with parents and guardians of Nevada Check Up participants as measured by an annual survey.

9.3 Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B)) (42 CFR 457.710 (d))

The primary source for measuring the five performance indicators will be an annual survey of the uninsured. The baseline will be established from a survey recently completed for Great Basin Primary Care Association by Decision Analytics, Inc. Additionally, data from the Bureau of the Census regarding poverty and insurance status, data for the Nevada Division of Insurance on health care covered lives and enrollment data for Medicaid and Nevada Check Up will be used to confirm the established performance indicators.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☐ The increase in the percentage of children with a usual source of care.
9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. ☐ Immunizations
9.3.7.2. ☐ Well child care
9.3.7.3. ☐ Adolescent well visits
9.3.7.4. ☐ Satisfaction with care
9.3.7.5. ☐ Mental health
9.3.7.6. ☐ Dental care
9.3.7.7. ☐ Other, please list: _____

9.3.8. ☐ Performance measures for special targeted populations.

9.4 ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42 CFR 457.720)

9.5 ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42 CFR 457.750)

The state's plan for the assessments and reports will include an annual update of a survey on insurance coverage for children in Nevada. This survey will initially be used to determine the extent of coverage and related crowd-out issues, but will be designed to allow for additional questions on health status, access to care and other issues as appropriate.

The state will also perform surveys of families on the program regarding access to care, grievance resolution and overall satisfaction. HEDIS reporting will be evaluated for quality of health coverage.

The information will be compiled by state staff and will address each of the performance goals included in Section 9.2. Variances will be addressed and evaluated to determine policies to improve the performance of the program. Also, performance goals will be reevaluated and changes made as appropriate.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))(42 CFR 457.720) (42 CFR 457.720)

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42 CFR 457.710 (e)) (42 CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42 CFR 457.135) (42 CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(c) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42 CFR 457.120(a) and (b))

Public input on the design and implementation of the plan has been accomplished through various means:

a) The Department of Human Resources prepared a four-page outline designed as a program framework. The outline was used to solicit public comment at four public hearings held throughout the state:

October 22, 1997 in Las Vegas
December 4, 1997 in Fallon
December 5, 1997 in Reno
December 10, 1997 in Las Vegas

b) The Legislative Committee on Health Care is a standing committee of Nevada's Legislature. The Committee held monthly meetings for a period of time after October 1997, at which the Nevada Check Up program was discussed. In addition to six legislators, approximately 25 other interested parties were also represented including:

- State agencies
- County agencies
- Hospitals
- Labor unions
- Health Maintenance Organizations (HMOs)
- Physicians and other health professionals
- Federally Qualified Health Centers (FQHC)
- Native American Advocacy Groups
- American Association of Retired Persons
- Legal Services Statewide Advocacy Office
- Children's Advocacy groups

The recommendations of the legislative body as well as the comments from the public and private sectors were taken into consideration in the drafting of the State Plan. Once available for distribution, copies of the State Plan were mailed to all persons who requested a copy in writing; and to all interested person and entities who participated in the initial public hearing process previously described. The state plan is also available through the Internet on the DHCFP/Nevada Check Up website.

In order to ensure ongoing involvement with the public, Nevada Check Up works closely with other public agencies and the Covering Kids and Families (CKF) Coalition. The Coalition monitors the progress of two local outreach projects in Northern and Southern Nevada, and rural outreach activities targeted at sustaining the CKF goals of outreach, coordination and

simplification. Coalition members are recruited from a broad segment of the community and their mission is to promote awareness of children's health care coverage through the SCHIP and Medicaid programs.

Nevada Check Up notifies all applicants and participants of changes to the program in writing. Program modifications relating to enrollment levels, eligibility criteria and/or cost sharing require public hearings. The public hearings are widely advertised as to date, time, location and subject matter.

9.9.1. Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42 CFR 457.120 (c))

The Department of Health and Humans Services (DHHS) and the Tribes, Indian Health Service, Tribal Organizations and Urban Indian Organizations (Tribes and I/T/U) residing within the State of Nevada have established an agreement in accordance with the established Tribal Consultation Process. NCU follows the same process as the Nevada Medicaid State Plan.

Representatives of Indian tribal organizations and advocacy groups are members of the Statewide Covering Kids Coalition, which conducts meetings and also includes representatives from Medicaid and Nevada Check Up.

Nevada Check Up participates in Native American Advisory Council meetings, as required by state law, to provide information to the council and to receive advice about the effectiveness of certain marketing and training activities. Nevada Check Up has conducted training in application completion, along with the necessary inclusion of required documentation, for Tribal Clinic staff. This training allows the clinics to help their patients complete a Nevada Check Up application and attach the required documents before it is submitted to the state. This training has reduced the number of applications placed in pending status because of missing information.

Nevada Check Up staff attends and participates in quarterly Inter-Tribal Council meetings and other events.

For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65 (b) through (d).

9.9.2 Public notice is provided pursuant to NRS 422.2368. Public hearing was provided for the sections related to citizenship, premiums, transportation and newborn SSN requirements. Appropriate publishing and postings were completed on November 6, 2009 and the hearing was conducted on December 8, 2009 for policies related to citizenship. Premiums policies were appropriately published and postings were completed on February 5, 2010 with the hearing conducted on March 9, 2010 so that anyone interested could comment. Transportation policies were published and postings were completed on July 22, 2011 the hearing was conducted on August

23, 2011. The eligibility manual was posted for public hearing August 12, 2011 and the hearing was conducted on September 13, 2011.

Public notice is provided pursuant to NRS 422.2368. Public hearing was provided for the sections related to adding back services per legislative directive effective July 1, 2009. Appropriate publishing and postings were completed on June 12, 2009 and the hearing was conducted on July 14, 2009 so that anyone interested could comment.

For updates effective September 1, 2008, public notice is provided pursuant to NRS 422.2368. Public hearing was provided for the changes to established coverage in this State Plan on August 26, 2008. Appropriate publishing and postings were completed on July 25, 2008 and the hearing was conducted to solicit feedback.

Public notice is provided pursuant to NRS 422.2368. Public hearing was provided for the sections related to the premium increase in this State Plan on March 11, 2008. Appropriate publishing and postings were completed on February 5, 2008 and the hearing was conducted so that anyone interested could comment.

For the proposal to eliminate provisional enrollment, public notice was provided pursuant to NRS 422.2368. The public hearing was conducted on July 13, 2004. Appropriate publishing and postings were completed in timely fashion and the hearings were conducted in a manner that encouraged interested parties to express their opinions.

9.10 Provide a one year projected budget. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

A suggested financial form for the budget is attached. The budget must describe:

- Planned use of funds, including:
  1. Projected amount to be spent on health services.
  2. Projected amount to be spent on administrative costs, such as: outreach, child health initiatives, an evaluation; and
  3. Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-federal plan expenditures, including any requirements for cost sharing by enrollees.

- In July 2004, Nevada Check Up discontinued the practice of provisional enrollment. Although the actual impact is unknown, it appears to be budget neutral.

The budget for the Nevada Check Up program is included below for Federal Fiscal Years (FFY) 2003 and 2004. The amounts represent the maximum funding that is being committed to the program, even though full enrollment may not be achieved. Actual cost may be significantly lower. The state's share of funding comes through appropriations from the State General Fund.

CHIP Budget Template

STATE: NEVADA Federal Fiscal Year	FFY Budget FFY 2012	Budget Increase/ decrease For Requested SPA FFY 2012	New Budget with SPA Budget Increase/ decrease FFY 2012
State's enhanced FMAP rate	**69.34/30.66**	**69.34/30.66**	**69.34/30.66**
Benefit Costs			
Insurance payments	$ 00	$ 00	$ 00
Managed care	$ 26,021,136	$ (844,059)	$ 25,177,077
per member/per month rate			
Fee for Service	$ 9,709,321	$ (202,306)	$ 9,507,015
Total Benefit Costs	$ **35,730,457**	$ **(1,046,365)**	$ **34,684,092**
(Offsetting beneficiary cost sharing payments)	$ (1,595,613)	$	$ **(1,595,613)**
Net Benefit Costs	$ **34,134,844**	$ **(1,046,365)**	$ **33,088,479**
Administration Costs			
Personnel	$ 1,429,601	$	$ 1,429,601
General administration	$ 1,449,975	$	$ 1,449,975
Contractors/Brokers	$ 00	$ 00	$ 00
Claims Processing	$ 33,458	$ 00	$ 33,548
Outreach/marketing costs	$ 00	$ 00	$ 00
Other	$ 00	$ 00	$ 00
Total Administration Costs	**$ 2,913,034**	**$**	**$ 2,913,034**
10% Administrative Cap (Net Benefit Costs /9)	$ 3,792,760	$	$ 3,676,498
Federal Share	$ 25,688,999	$ (725,549)	$ 24,963,449
State Share	$ 11,358,879	$ (320,816)	$ 11,038,064
TOTAL COSTS OF APPROVED CHIP PLAN	**$ 37,047,878**	**$ (1,046,365)**	**$ 36,001,513**

Source of State Funds: State General Fund

FFY projected numbers based on State Fiscal Year (SFY) 2010 actual numbers and SFY 2011 budgeted numbers.

FFY 2011 Actual Average Monthly Enrollment: 21,234
FFY Actual Average Annual Benefit Child per Child: $
FFY 2012 Projected Average Monthly Enrollment 18,033
FFY 2012 Projected Average Annual Benefit Cost per Child: $ 1,225

FFY 2009 projected savings are SFY 2009 budget projection for capping dental at $600, eliminating orthodontia, and eliminating non-medical vision care: $698,966.00.

SFY 2010 projected cost for adding back orthodontia, EPSDT, non-medical vision and removal of dental cap is ($997, 318.00) per SFY.

SFY 2008	BUDGETED ENROLLMENT	ACTUAL ENROLLMENT	BUDGET VS. ACTUAL ENROLLMENT	GROWTH RATE BUDGETED	GROWTH RATE ACTUAL
July	29,723	**29,728**	**-5**	**-9.13%**	**-0.57%**
August	29,699	**29,969**	**-270**	**-0.08%**	**0.81%**
September	29,851	**30,204**	**-353**	**0.51%**	**0.78%**
October	29,686	**29,919**	**-233**	**-0.55%**	**-0.94%**
November	29,757	**30,184**	**-427**	**0.24%**	**0.89%**
December	30,005	**29,456**	**549**	**0.83%**	**-2.41%**
January	30,213	**29,178**	**1,035**	**0.69%**	**-0.94%**
February	30,459	**28,896**	**1,563**	**0.81%**	**-0.97%**
March	30,572	**28,751**	**1,821**	**0.37%**	**-0.50%**
April	30,974	**28,158**	**2,816**	**1.31%**	**-2.06%**
May	31,128	**27,625**	**3,503**	**0.50%**	**-1.89%**
June	31,306	**26,832**	**4,474**	**0.57%**	**-2.87%**
Monthly Average	**30,281**	**29,075**	**Annual Growth Rate**	**-4.45%**	**-2.54%**

SFY 2009	BUDGETED ENROLLMENT	ACTUAL ENROLLMENT	BUDGET VS. ACTUAL ENROLLMENT	GROWTH RATE BUDGETED	GROWTH RATE ACTUAL
July	26,593	**25,998**	**595**	**-15.05%**	**3.11%**
August	26,357	**25,889**	**468**	**-0.89%**	**-0.42%**
September	25,032	**24,881**	**151**	**-5.03%**	**-3.89%**
October	25,000	**24140**	**860**	**-0.13%**	**-2.98%**
November	25,000	**23893**	**1,107**	**0.00%**	**-1.02%**
December	25,000	**23356**	**1,644**	**0.00%**	**-2.25%**
January	25,000	**22888**	**2,112**	**0.00%**	**-2.00%**
February	25,000	**22525**	**2,475**	**0.00%**	**-1.59%**
March	25,000	**22527**	**2,473**	**0.00%**	**0.01%**
April	25,000	**22437**	**2,563**	**0.00%**	**-0.40%**
May	25,000	**22562**	**2,438**	**0.00%**	**0.56%**
June	25,000	**22444**	**2,555**	**0.00%**	**-0.52%**
Monthly Average	**25,248**	**23,628**	**Annual Growth Rate**	**- -16.62%**	**-18.73%**

SFY 2010	BUDGETED ENROLLMENT	ACTUAL ENROLLMENT	BUDGET VS. ACTUAL ENROLLMENT	GROWTH RATE BUDGETED	GROWTH RATE ACTUAL
July	25,998	22,101	-3,897	3.99%	1.53%
August	25,889	21,999	-3,890	-0.42%	-0.46%
September	24,881	21,576	-3,305	-3.89%	-1.92%
October	24,140	21,534	-2,606	-2.98%	-0.19%
November	23,893	21,823	-2,070	-1.02%	1.34%
December	22,737	21,515	-1,222	-4.84%	-1.41%
January	22,888	21,623	-1,265	0.66%	0.50%
February	22,525	21,858	-667	-1.59%	1.09%
March	22,527	22,125	-402	0.01%	1.22%
April	22,640	21,537	-1,103	0.50%	-2.66%
May	22,753	21,612	-1,141	0.50%	0.35%
June	22,867	21,255	-1,612	0.50%	-1.65%
Monthly Average	**23,645**	**21,713**	**Annual Growth Rate**	**-8.57%**	**-5.33%**

SFY 2011	BUDGETED ENROLLMENT	ACTUAL ENROLLMENT	BUDGET VS. ACTUAL ENROLLMENT	GROWTH RATE BUDGETED	GROWTH RATE ACTUAL
July	22,737	21,469	-1,268	-0.57%	1.01%
August	22,937	21,430	-1,507	0.88%	-0.18%
September	23,187	20,898	-2,289	1.09%	-2.48%
October	23,487	21,146	-2,341	1.29%	1.19%
November	23,837	21,299	-2,538	1.49%	0.72%
December	24,237	21,002	-3,235	1.68%	-1.39%
January	24,687	21,201	-3,486	1.86%	0.95%
February	25,187	21,188	-3,999	2.03%	-0.06%
March	25,737	20,951			
April	26,337	21,368			
May	26,987	21,228			
June	27,677	21,139			
Monthly Average	**24,753**		**Annual Growth Rate**		

Section 10. Annual Reports and Evaluations (Section 2108)

10.1 Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1)(2)) (42 CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uninsured low-income children and other factors requested as part of the Annual Report template provided by CMS.

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. (42 CFR 457.710 (e))

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-D ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the state to the Human Resources and Services Administration for posting on the Insure Kids Now! website. Nevada met the August 4, 2009 deadline for posting of both the dental package and dental provider information. The provider list updates will be sent the first of the month following a quarter.

Section 11. Program Integrity (Section 2101 (a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the states' Medicaid plan, and continue to Section 12.**

11.1. ☒ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101 (a)) (42 CFR 457.940 (b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107 (e)) (42 CFR 457.935 (b))

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents).

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information).

11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals).

11.2.4. ☒ Section 1128A (relating to civil monetary penalties).

11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☒ Section 1128E (relating to the national health care fraud and abuse data collection program).

Section 12. Applicant and enrollee protections (Section 2101 (a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**

Eligibility and Enrollment Matters

12.1. Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

Enrollees and applicants are informed of program eligibility requirements at the time of application and re-enrollment. In addition, they are assured of and informed about timely processing of application requirements. They are informed of their right to request a review for the following adverse actions:

- Denial of eligibility;
- Failure to make a timely determination of eligibility;
- Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.

Enrollees and applicants are provided a written notice of decision explaining any adverse actions regarding eligibility and enrollment and have the right to request a review, followed by a state fair hearing, regarding such action. In addition, they have the right to request services continue pending the outcome of the review and hearing process. The agency will continue services if the enrollee requests a review and/or hearing in writing within 10 days of the notice date.

A review and/or hearing will not be granted if the sole issue is a change in the State Plan, federal or state law, requiring automatic change in eligibility, or a change in the health benefits package that affects all applicants or enrollees, or a group of applicants or enrollees without regard to their individual circumstances.

The applicant or enrollee may be granted an opportunity for a review and a fair hearing, if a written request for such is submitted within 30 days after the date of the notice of the decision. The review is conducted by a Reviewing Officer (RO) who is the Chief of Medicaid and Nevada Check Up Services or his/her designee. The RO must be an impartial party who has not been involved in the investigation or initial determination of the adverse action in question. The RO sets the review in a timely manner, based on the need for a standard review, or submitted justification from the health plan or physician for an expedited review. Enrollees or applicants may represent themselves or have a representative(s) of their choosing participate in the review process, which may be conducted in person or by telephone. Enrollees have the right to review their files and other applicable information relevant to the review of the decision.

The RO prepares a written decision based on documentation in the case file and any supporting documentation or statements provided during the review process. The RO then provides the written decision in a timely manner as per the standard or expedited review mandates.

The written decision includes the date of the review, the findings of fact, any conclusions of law, the decision whether to affirm the adverse action, and the enrollee's or applicant's right to request a state fair hearing pursuant to state statute.

If the applicant requests a hearing, the request for hearing is referred to the DHCFP Hearings and Policy Unit, which will notify the Department of Administration (DOA) to schedule the fair hearing. In providing a fair hearing through DOA, the conduct of such is pursuant to Medicaid Services Manual Chapter 3100.

Health Services Matters

12.2. Please describe the review process for health services matters that complies with 42 CFR 457.1120.

Participants are assured of their opportunity for an external review of the following adverse actions:

- Delay, denial, reduction, suspension or termination of a health services, in whole or in part, including a determination about the type or level of services; and
- Failure to approve, furnish, or provide payment for health services in a timely manner.

Participants are provided a written notice of decision explaining any adverse actions regarding health services matters and have the right to specifically request an external review, followed by a state fair hearing, regarding such action. In addition, they have the right to have services continue pending the outcome of the review and/or hearing.

A review and/or hearing will not be granted if the sole issue is a change in the State Plan, federal or state law requiring automatic change in eligibility, or a change in the health benefits package that affects all applicants or enrollees, or a group of applicants or participants without regard to their individual circumstances.

The applicant or participant may be granted an opportunity for a review and a fair hearing if a written request for such is submitted within 30 days after the date of the notice of the decision. The review is conducted by a Reviewing Officer (RO) who is the Chief of Medicaid and Nevada Check Up Services or his/her designee. The RO must be an impartial party who has not been involved in the investigation or initial determination of the adverse action in question. The RO sets the review in a timely manner, based on the need for a standard review or submitted justification from the health plan or physician for an expedited review. Participants may represent themselves or have a representative(s) of their choosing participate in the review process, which may be conducted in person or by telephone. Participants have the right to review their files and other applicable information relevant to the review of the decision. If the participant requests an external review, the request for review is forwarded to the Hearings and Policy Unit and is scheduled in a timely manner by the unit supervisor or his/her designee.

The RO, or Hearings Supervisor, prepares a written decision based on documentation in the case file and any supporting documentation or statements provided during the review process. The RO, or Hearings Supervisor, then provides the written decision in a timely manner in accordance with the standard or expedited review mandates. The written decision includes the date of the review, the findings of fact, any conclusions of law, the decision whether to affirm the adverse action, and the enrollee's right to request a state fair hearing pursuant to state statute.

The request for hearing is referred to the DHCFP Hearings Unit, which will notify the Department of Administration (DOA) to schedule the hearing requested. In providing a fair hearing through DOA, the conduct of such a hearing is pursuant to Medicaid Services Manuel Chapter 3100.

Premium Assistance Programs

12.3. If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable.